PRINTED: 01/23/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (DELITIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED a. Building B. WING 445024 01/09/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3209 BRISTOL HWY NHC HEALTHCARE, JOHNSON CITY JOHNSON CITY, TN 37601 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 45 PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XB) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F-221 F 221 F 221 483.13(a) RIGHT TO BE FREE FROM SS=D PHYSICAL RESTRAINTS Resident #108 will not have side rails used as restraints. The Resident Care The resident has the right to be free from any Coordinator will perform a comprehensive physical restraints imposed for purposes of assessment of this resident's mobility and discipline or convenience, and not required to treat the resident's medical symptoms. safety devices and ensure the proper devices are in use, without restraining the resident. This REQUIREMENT is not met as evidenced by: All residents will be evaluated by the Based on medical record review, observation, respective Resident Care Coordinator for and interview, the facility failed to ensure the potential of side rails being used as residents were free from restraints for one restraints. resident (#108) of fifty residents reviewed. No resident, unless properly assessed, The findings included: will have all four side rails up. A new side rail assessment will be implemented now, Resident #108 was admitted to the facility on and in conjunction with each resident's January 23, 2009, with diagnoses including End quarterly review to ensure side rails are Stage Dementia, Peripheral Neuropathy. being used appropriately. In-service Aftercare/healing Trauma Fracture Left Hip. meetings will be held with nursing staff to Osteoarthritis, Osteoporosis, review side rail usage. Hypercholesterolemia, Diabetes Mellitus type II. Hypertension, Coronary Artery disease, Anxiety, The Resident Care Coordinator will be Post-op Anemia, and Insumnia. responsible for reviewing each resident for side rail usage at least quarterly on a Medical Record Review of the Care Plan dated routine basis. A review of each resident December 6, 2012, revealed no interventions for and their current side rail status, including restraint use. Further review of the Care Plan the corrective actions from this plan of dated December 6, 2012 revealed no correction, will be presented at the interventions for siderails and "...bed to be in the facility's monthly QA meeting in February. lowest position with mat on floor..." Continued The DON, ADON, and Resident Care medical record review revealed no documentation Coordinators will perform visual audits of of a Physician's Order for the use of the siderails. each resident's bed rails weekly times 2/23/2013 two weeks. Observation on January 9, 2013, at10:40 a.m., revealed four side rails in the up position with

LABORATORY DIRECTOR'S OR PROVIDER/SU PPLIER REPRESENTATIVE'S SIGNATURE

siderall covers in place. Further observation

TITLE (X8) DATE

Any deficiency statement ending with an ast sisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of shryby whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsclute

Event ID: 7UKE11

Facility ID: TN9009

if continuation sheet Page 1 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DEFITIENCATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|---------------------------------|----------------------------|
| | | 445024 | B. WING | | 01/09/2013 | |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | 3 | TREET ADDRESS, CITY, STATE, ZIP (3209 BRISTOL HWY JOHNSON CITY, TN 37601 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST IN PRECEDED BY FUIL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REPERENCED TO T DEFICIENCE | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| | revealed the reside the right upper side Interview with Certified Nurse's A 2012 at 8:10 a.m., able to roll in the bit the resident from relative with the F (RCC #2), on Januthe resident's room were in the up posiable to volunatarily Further interview was to be in the low floor at bedside. Renot in the low posit Interview with the I the upstairs confer 2013, at 9:45 a.m., "four side rails or restraintsthe side from coming out of split and the reside between the rails revealed the DON distance was between the rails | ent lying on the left side against brail. Iffed Nurse's Assistant #3 and sesistant #4, on January 10, confirmed the resident was ed and the sideralis prevented offing cut of the bed. Resident Care Coordinator rary 9, 2013, at 10:40 a.m., in a, confirmed the four sideralis ition and the resident was not able to get out of the bed. If the RCC #2 confirmed the bed we position with a mat on the RCC #2 confirmed the bed was ion. Director of Nursing (DON) in the bed were not a rails prevented the resident if the bed the bed were not a rails prevented the resident if the bed the bed was not able to say how much seen the lower and upper rails, with the DON confirmed when estraint according to federal explained, the DON confirmed a restraint. | F 22 | | | |
| | | onduct initially and periodically accurate, standardized | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7UKE11

Facility ID: TN9009

If continuation sheet Page 2 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | (X2) MULTI | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | | |
|--|--------------------------|---|---|-------------------------------|--|--|----------------------------|
| | | | 445024 | B. WING_ | | 01/09 | /2013 |
| | | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | 3 | REET ADDRESS, CITY, STATE, ZIP CODE IZD9 BRISTOL HWY IOHNSON CITY, TN 37601 | | |
| ı | (X4) ID PREFIX YAG | (EACH DEFICIENCY | ITEMENT OF DEFICIENCIES Y MUST BI: PRECEDED BY FULL SCIDENT FYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DAYE |
| | F 272 | functional capacity. A facility must mak assessment of a reresident assessment of a resident following: Identification and decustomary routine. Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-Physical functionin Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of the additional assessments State (MDS); as | e a comprehensive esident's needs, using the ent instrument (RAI) specified assessment must include at lemographic information; patterns; being; g and structural problems; and health conditions; nall status; eard pacedures; al; summary information regarding essment performed on the care the completion of the Minimum | F 272 | Resident #209 will have an inclassessment. The Resident Care Coordinator review all residents who are interested and ensure they have an incorrassessment. After the discontinued service expert incontinence management we have updated our incontinence assessment will be implemented now for all resident conjunction with each resident admission and annual review be Resident Care Coordinator. The DON and ADON will each sample of five incontinent resident eview their record for an incorrassessment; weekly times two to next QA committee in Februwill be routine annual reviews coordinator and Resident Care Coordinator. | r will continent itinence of an ent group, ence dated oe ints and in 's oy the select a dents and itinence , and report eary. There by the MDS | 2/23/2013 |
| | | This REQUIREME by: | NT is not met as evidenced | | | | |

FORM CMS-2557(02-99) Previous Versions Obsoletti-

Event ID: 7UKE11

Facility ID: TN9009

If continuation sheet Page 3 of 15

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| OC: VICE I C | I VINIEDIO/CIE | O MICHIGARY OF MANCE | | | | | |
|--|--|---|---|-----------|---|-------------------------------|--------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PRCVIDER/SUPPLIER/CLIA IDENITIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. SUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 445024 | B. WI | ₩ <u></u> | | 01/0 | 9/2013 |
| NAME OF PROVIDE | | N CITY | | 32 | EET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37801 | | |
| | EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BILL PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | COMPLETION DATE |
| Basithe frasse (#20) The Resident August for The Chron Right Med Asses Sept frequence evaluation of the Evaluation Med performance would resident Med Giscon Med Sum | acility failed to sament for inc sament and Exament and Exament and Exament and Exament incontinent at the Urinary Incontinent and treat incontinent and treat incontinent and treat inc sament and treat inc sament and treat incontinent and treat incontinent and treat inc | record review and interview, complete a comprehensive continence for one resident ents reviewed. ed: admitual to the facility on with diagnoses including Failure aulicer (in Coccyx, Dementia, Pain, Hypothyroidism, and item of the Urinary Incontinence evaluation Form dated 2, revea ed "Pt (patient) is ent of bladder. Will consult ce experts)." Additional review intinence: Assessment and in September 18, 2012, ence Management referral to | F | 272 | | | |

FORM CMS-2567(02-98) Previous Versions Obsolete

Event ID:7UKE11

Facility ID; TN9009

If continuation sheet Page 4 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES F CORRECTION | (X1) PRIVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------------------------|-----|--|-------------------------------|----------------------------|
| | | 445024 | B. Wii | NĞ_ | | 01/09/2013 | |
| | ROVIDER OR SUPPLIER LITHCARE, JOHNSO | N CITY | • | 3: | WET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST (II: PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDERS PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY) | DULD BE | (X5) COMPLETION DATE |
| F 323 SS=D | Interview with Certi 5), on January 9, 2 station 1, revealed of physically movin independently, nev urinate, and was a bladder. Interview with the I the Resident Care January 9, 2013, a room, revealed No visit from the incon November 2, 2012 void therapy but "II only note being the 2012. Interview with the I 9, 2013, at 1:29 p.I station, confirmed for bladder incontin 483.25(h) FREE O HAZARDS/SUPEF The facility must e environment remai as is possible; and | fied Nursing Assistant (CNA# 013, at 12:37 p.m., in nursing the resident was not capable g to the bathroom er expressed the need to ways incontinent of bowel and Director of Nursing (DON) and Coordinator (RCC #1), on t 12:40 p.m., in the conference vember 1, 2012, was the first minence group and on, the resident was started on mere is no record of it" with the cone dated November 15, DON and RCC #1 on January m., at the Station 1 nursing a comprehensive assessment mence was not completed. FACCIDENT RVISICN/DEVICES Insure that the resident inside as free of accident hazards each resident receives ion and assistance devices to | | 323 | | | |
| | by: Based on medica | NT is not met as evidenced record review, observation, facility railed to implement | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsokels

Event ID:7UKE11

Facility ID: TN9009

If continuation sheet Page 5 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDI: NTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY | | | |
|--|--|--|--------|---|---|---|--------------------|
| | | 445024 | B. Wit | 4G_ | | 01/09/2013 | |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | • | 33 | EET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST IN PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | ULD BE | COMPLETION DATE |
| F 323 | interventions included reduce the risks of consistent with the resident (#108) of it. The findings included Resident # 108 was January 23, 2009, Stage Dementia, F. Aftercare/healing Tosteoarthritis, Osteoarthritis, Osteoarthritis, Osteoarthritis, Compost-op Anemia, a Medical record revibed alarm, and material record revibed alarm, and material record review of a dated April 1, 2012 chair) Alarms, low Observation of the 2012, at 2:10 p.m. alarm in place and and not in the low observation on Jac revealed the resideraised position. | ting assistive devices to an accident that were needs and plan of care for one lifty residents reviewed. ed: s admitted to the facility on with diagnoses including End Peripheral Neuropathy, Frauma Fracture Left Hip, eoporosis, mia, Diabetes Mellitus type II, ponary Artery disease, Anxiety, and Insomnia. The of the Care Plan dated evealed "Bed in low position, at on floor" Continued the Care Plan dated prevaled "Bed in low in and mat on floor" Medical Physician's Telephone Order the Care Plan dated the provision of the Care Plan dated the care plan dated the provision of the Care Plan dated the care plan dated the provision of the Care Plan dated the provision. The provision of the plan in a raised position position. Continued the bad in a raised position position. Continued the pad with the bed in a plan in bad with the bed in a part in bad with the bed in a position confirmed the provision of the pad with the bed in a part in bad with the bad in | | 323 | Resident #108 will have bed alar place and the bed in low position planned. All residents will be evaluated by respective Resident Care Coord the potential of safety devices not used as care planned, and will experience meetings will be held nursing staff on the proper use of accidents. The licensed nursing staff on the proper use of accidents. The licensed nursing sasigned to each shift will be residented to each resident's saff devices at least once per shift accommunicating each resident's care to the respective CNA each. The Resident Care Coordinator perform audits weekly times threat of all patients to ensure safety din use as care planned. DON owill perform monthly checks of a residents with safety devices an monthly QA committee. | y the linator for ot being ensure the e(s) are in with of e the risks e sponsible ety nd plan of h shift. will ee weeks levices are r designee all | 2/23/2013 |

FORM CMS-2567(02-99) Previous Varsions Obsolet:

Event I0:7UKE11

Facility ID: TN9009

If continuation sheet Page 6 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|-----|--|-------------------------------|----------------------------|
| | | 445024 | B. Will | 1G | | 01/09 | /2013 |
| | ROVIDER OR SUPPLIER ALTHGARE, JOHNSO | N CITY | | 32 | EET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT: OF DEFICIENCIES Y MUST RIS PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDERS PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 323 F 425 \$\$=D | Interview with LPN 8:05 a.m., in the rebed was not in the 483.60(a),(b) PHAI ACCURATE PROCETHE facility must prodrugs and biological them under an agriculture and personal law permits, but on supervision of a lice. A facility must prove (including proceduracquiring, receiving administering of all the needs of each. The facility must enable a licensed pharma. | #1 on Lanuary 10, 2013, at sident's room confirmed the low position. RMACEUTICAL SVC - CEDURIES, RPH rovide routine and emergency als to its residents, or obtain element described in part. The facility may permit nel to eximinister drugs if State by under the general ensed nurse. ide pharmaceutical services resident assure the accurate g, dispensing, and I drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation the provision of pharmacy | | 323 | | | |
| | by: Based on medical and interview, the taccurate acquiring | | | | | | |

FORM CMS-2567(02-89) Previous Versions Obsoleta

Event ID: 7UKE11

Facility IO: TN9009

If continuation sheet Page 7 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PRC | | (X1) PRC VIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|------------------------------------|--|---|---------------------|--|---|----------------------------|
| | | 445024 | B. WING | | 01/09 | /2013 |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | ON CITY | 32 | EET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BI! PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | (LLD BE | (05) COMPLETION DATE |
| F 425 | Resident #172 was 25, 2012, with diag Disease, Coronary Coumadin Therapy Chronic Renal Fall Depression, and Ir Medical record rev Order dated June (Klonopin, an antia hours for anxiety. Medical record rev Evaluation dated Cresident was curre twice daily for anximulation dated Cresident was curre twice daily for anximulation for Medical record rev Physician's Recap revealed the order 12 hours as needs however, the Physician's Recap orders for 2013, revealed no Clonazepam 0.5 m Review of the Medical for October and January 2013 continued to recei 12 hour at 8:00 automatical for an at 8:00 automatical for at 8:00 automatical for a continued to recei 12 hour at 8 | s admitted to the facility on June goeses including Parkinson's Artery Disease, Long-Term y, Congestive Heart Failure, fure, Acute Anxiety, Dementia, asomnia. New revealed a Physician's 25, 2012, for Clonazapam anxiety) 0.5 mg. every twelve of a Medical Psychiatry October 10, 2012, revealed the ently on Clonazepam 0.5 mg. increased anxiety." New of the November of Clonazepam 0.5 mg. every ed (PRN) for acute anxiety sician's Order no longer ne order for Clonazepam 0.5 urther naview of the Physician's December 2012 and January order for the routine order for | F 425 | F-425 All klonopin orders for resident to been reviewed with the doctor a psychiatric NP for clarification or klonopin orders have been discontinuous been reviewed to ensure the comedications are being administrations are being administration accurated to the Resident Care Coordinated order and administration accurated to electronic MAR procedures, order-check procedure will be implemented. The DON, ADON, and Resident Coordinator will perform weekly a sample of residents on each of three weeks to ensure medication ordered. Monthly monitoring by consultant pharmacist will focus issue and be reported to the Oxicommittee. | f use; all continued. Is have meet seed. reviewed tor for acy. ced on as related A 24-hour t Care audits of unit for ons are ented as a the son this | 2/23/2013 |
| | | | <u> </u> | | · . | <u></u> |

FORM CMS-2567(02-99) Previous Versions Obsok-89

Event ID:7UKE11

Facility ID: TN9009

If continuation sheet Page 8 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0838-0391

| | ATEMENT OF DEFICIENCIES (X1) PREVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--------------------------|---|-------------------------------|----------------------------|
| | ' | 445024 | B. WING _ | | 01/09/2013 | |
| i | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | |
| (X4) IO PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | DULD BE | (X8) COMPLETION DATE |
| F 425 | dated January 4, 2 (discontinue) Klond disuse." Review of the MAF the resident receiv January 4, 2013, a was then discontinued. Observation on Jarevealed the resider chair in the resider Interview with the lat the 200 Hall Nur 2012, at 2:30 p.m. have remained on daily and only the discontinued. Telephone intervie January 10, 2013, Physician's Recap by the pharmacy at the Physician's Reconfirmed no order discontinue the rottwice daily, and the included on the Physiciany 2013. Interview with the Coordinator on Jaconfirmed the resident in the resident in the coordinator on Jaconfirmed the resident in the coordinator on Jaconfirmed the resident in the resident in the coordinator on Jaconfirmed the resident in the resident in the resident in the resident in the coordinator on Jaconfirmed the resident in the | lew of a Physician's Order 013, revealed "d/c opin 0.5 mg, bid PRN due to R dated January 2013, revealed sed a Cionazepam 0.5 mg, on at 8:00 a.m., and the medication dued. nuary 9, 2013, at 2:00 p.m., ent sitting quietly in a broda | F 425 | | | |

FORM CMS-2867(02-99) Previous Vereiona Obsolute

Event ID:7UKE11

Facility HD: TN9009

If continuation sheet Page 9 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PRC-VIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------------------|--|---|----------------------------|
| | | 445024 | B. WING | | 01/09 | /2013 |
| NHC HEA | ROVIDER OR SUPPLIER LITHCARE, JOHNS | ON CITY | 32 Je | EET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 PROVIDER'S PLAN OF CORRE | COON | 0(5) |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST 412 PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X6) COMPLETION DATE |
| F 441 SS=D | The facility must infection Control safe, sanitary and to help prevent the of disease and in (a) Infection Control The facility must Program under w (1) Investigates, in the facility; (2) Decides what should be applied (3) Maintains a reactions related to (b) Preventing Si (1) When the Infection of the facility meant the sprayent the sprayent the sprayent the sprayent the sprayent the sprayent the facility meant and washing is professional prayers. (c) Linens Personnel must | establish and maintain an Program designed to provide a december and transmission fection. The Program establish an Infection Control controls and prevents infections and prevents infections are procedures, such as isolation, and to an individual resident; and ecord of incidents and corrective infections. The procedures are corrective infections. The procedures are infection ecord of incidents and corrective infections. The procedure infection ecord of infection, the facility must ent. The procedure infected as in lesions in the procedure infected as in lesions in the procedure staff to wash their indicated by accepted | F 441 | Hand hygiene during ice pass, under isolation precautions, we immediately reviewed with all sworking during this time. All residents who receive a wa have the potential to be affected hygiene while passing ice will be reviewed with all staff at in-ser meetings. In the event of another general precaution of all patients due to hand hygiene procedures for paid be specified to all staff in weight reminders by the infection rurse. The infection control nurse will monitoring of ice passes on eaweekly times three weeks, the QA committee for continued mecommendations. | ter pitcher ed. Hand be vice I isolation o a virus, bassing ice vritten and on control I perform ach unit | 2/23/2013 |

FORM CMS-2567(02-98) Previous Versions Obsolute

Event ID: 7UKE11

Facility ID: TN9009

If continuation sheet Page 10 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BU! | | LE CONSTRUCTION | (X3) DATE SU COMPLE | JRVEY TED | |
|--|--|---|-------------|-----------------|---|--------------|----------------------------|
| | | 445024 | B. Wil | iG | | 01/0 | 9/2013 |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | ON CITY | | 32 | EET ADDRESS, CITY, STATE, ZIF CODE 109 BRISTOL HWY DHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BI: PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HQULD BE | (XG) COMPLETION DATE |
| F 441 | by: Based on observa and interview, the disinfected hands residents. The findings includ Observation on Ja 200 hall several re facility was using it everyone. Observation on Ja the 200 hall, revea nursing assistant) pitchers with ice. CNA#1 entered re bed's water pitche filled the water pitche filled the water pitche filled the water pitche on the ice chest, fi and returned the v room. Continued went into room 20 and continued to p as CNA#1. Conti #1 and #2 entered and enter 204, wit 202, with one resid two residents. Co the CNA's did not resident's water pi | NT is not met as evidenced ation, review of facility policy, facility failed to ensure staff during the ice pass to the | | 441 | | | gregore season ge |
| | Literate of ignitive | handle i vitiniamonisti ili i mism | | | | | ļ |

FORM CMS-2587(02-99) Previous Versions Obsoleta

Event ID: 7UKE11

Facility ID: TN9008

If continuation sheet Page 11 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION (X2) DEN THICATION NUMBER: | | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | (X3) DATE SI COMPLI | URVEY ETÉO | |
|---|--|---|---------------------|--|--------------------------------|----------------------------|
| | | 445024 | B, WING | | 01/0 | 9/2013 |
| | ROVIDER OR SUPPLIER LITHCARE, JOHNS | | 18 | STREET ADDRESS, CITY, STATE, 219 CO 3209 BRISTOL HWY JOHNSON CITY, TN 37601 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEPICIENCIES CY MUST HI: PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY) | IN SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| F 441 | isolation precautil with objects (e.g. immediate vicinity immediate vicinity Interview with the 2013, at 9:45 a.m. the CNA's had not each resident's with the January 10, 2013 hallway, confirme after each patien staff are not to plon the ice chest. 483.75(j)(1) ADM The facility must services to meet facility is respons of the services. This REQUIREM by: Based on medic the facility falled ordered by the patien of the facility falled ordered by the patient facility falled ordered facility falled ordered by the patient facility falled ordered facility falled facility falled facility falled facility falled facility falled facility facility falled facility facility falled facility facility facility falled facility fac | d "e. before and after entering on setting6. i. after contact medical aquipment) in the y of the resident" CNA #1 and #2 on January 9, i., in the 200 hallway, confirmed of disinfected the hands after rater pitcher was filled with ice. Assistant Director of Nursing on 8, at 10:15 a.m., in the 400 at the staff are to disinfect hands to Continued interview confirmed ace the resident's water pitchers MINISTRATION provide or obtain laboratory the needs of its residents. The sible for the quality and timeliness MENT is not met as evidenced cal record review and interview, to obtain a laboratory test as hysician timely. | | | | |
| | Long-Term Cour | eview revealed a protime was | | Facility ID: TN9009 | if continuation she | est Page 12 of 1 |

FORM CMS-2667(02-99) Previous Versions Obscrete

Event ID: 7UKE11

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|--|--|--|----------------------------|
| | | 445024 | B. WING_ | | 01/09 | /2013 |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | 3 | REET AODRESS, CITY, STATE, ZIP CODE 1209 BRISTOL HWY JOHNSON CITY, TN 37601 | | : |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST HE PRECEDED BY FULL SCIDENT FYING INFORMATION) | (D PREFIX TAG | REFIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE |
| F 502 F 514 SS=D | obtained on Novem (International Norm Orders received we days and start alter day of 2.0 mg. and two days. Medical record rev the protime was obtain (seven days from c 28, 2012). Medical record rev protime/INR result Coumadin for one week. Interview with the 3 Nurse Supervisor a January 9, 2013 at protime had not be physiciam. 483.75(I)(1) RES RECORDS-COMFLE The facility must m resident in accordant standards and pranaccurately docume systematically organization to identiformation to identification and standards are cordinformation to identification and standards are cordinated to identifi | nber 28, 2012, with INR halized Ratio) result of 5.3. ere to hold Coumadin for two mating closage, every other 2.5 mg., and recheck INR in liew revealed no documentation plained on November 30, 2012, or review revealed the next sed on December 5, 2012, order received on November iew of the December 5, 2012, order received on November iew of the December 5, 2012, was 2.5, with orders to hold day and repeat lab in one is the 300 Nursing Station on 2:15 p.m., confirmed the ien obtained as ordered by the increase with accepted professional cities that are complete; ented; readily accessible; and anized. must contain sufficient ments; the plan of care and | | Lab orders for resident #172 we with the attending physician and resident's labs have been obtain ordered. All residents with orders for INR be reviewed routinely for accurate and weekly by the shift nurse are greater than weekly by the Resi Coordinator. INR labs will be monitored in the systems: lab calendar, lab log, a electronic MAR. The respective Resident Care C will monitor each resident with I twice per week for three weeks to QA committee for further mon recommendations. | the ned as labs will acy: daily nd no dent Care and Coordinator NR labs and report | 2/23/2013 |

FORM CMS-2587(02-99) Provious Versions Obsoleus

Event (0:7UKE11

Facility ID: TN9009

If continuation sheet Page 13 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | MULTIPLE CONSTRUCTION (X3) DATE COMP | | URVEY | |
|---|--|--------------------------|---|---|----------------------------|--|
| | 445024 | B. WING 01/0 | | 01/09 | /2013 | |
| NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, JOHNSO | ON CITY | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 209 BRISTOL HWY OHNSON CITY, TN 37601 | | | |
| PREFIX (EACH DEFICIENC | ATEMENT (IF DEFICIENCIES Y MUSY HE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | FROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| This REQUIREME by: Based on medica and interview, the accurate clinical re sampled residents The findings include Resident #172 wa 25, 2012, with diagonisease, Coronary Cournadin Therap Chronic Renal Fail Depression, and in Medical record rev Order dated June (Klonopin, an antic hours for anxiety.) Medical record rev Evaluation dated of resident was curre twice daily for anxi "add PRN (as ne every 12 hours for Medical record rev Physician's Recay revealed the orde 12 hours as need however, the Physician's recent | ening conducted by the State; s. ENT is not met as evidenced I record review, observation, facility failed to maintain an accord for one (#172) of fifty i. ded: s admitted to the facility on June goses including Parkinson's y Artery Disease, Long-Term by, Congustive Heart Failure, illure, Acute Anxiety, Dementia, | Ė 514 | All klonopin orders for resident been reviewed with the doctor psychiatric NP for clarification klonopin orders have been distanced in the commercial orders are being administed accumented correctly. All residents on klonopin will be by the Resident Care Coordinator, administration, and doctored, administration, and doctored in the cleatronic MAR procedures order-check procedure will be implemented. The DON, ADON, and Reside Coordinator will perform week a sample of residents on each three weeks to ensure medication ordered. Monthly monitoring consultant pharmacist will focus issue and be reported to the Coordinator further monitoring recommendations. | and of use; all continued. as have correct stered and e reviewed ator for umentation viced on as related . A 24-hour ent Care ly audits of unit for ations are mented as by the us on this QA | 2/23/2013 | |

FORM CMS-2587(02-99) Previous Versions Obsoleto

Event ID: 7UKE11

Facility ID: TN8009

If continuation sheet Page 14 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | OLTIPLE CONSTRUCTION DING | | (X3) DAYE SURVEY COMPLETED 01/09/2013 | |
|---|--|--|---------------------|---|-----------------------------------|---|--|
| | | 445024 | B. WING | | 01/0 | | |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | ON CITY | | STREET ADDRESS, CITY, STATE, ZW 3209 BRISTOL HWY JOHNSON CITY, TN 37601 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT ()F DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 514 | mg. twice daily. Fi Recap Orders for I 2013, revealed no Clonazepam 0.5 m Review of the Med (MAR) for October and January 2013 continued to receivate the record reversed and January 12 dosages given. Medical record reversed January 4, 20 discontinue) Klondisuse." Review of the MAR the resident receival January 4, 2013, a medications was the line remained on daily and only the discontinued. Telephone interview January 10, 2013, Physician's Recapt by the pharmacy at the Physician's Recapt by the pharmacy at the Physician's Recapt the Physician' | urther review of the Physician's December 2012 and January order for the routine order for ag. twice dally. dication Administration Records r., November, December 2012, revealed the resident we Clonazepam 0.5 mg. every m. and 8:00 p.m. documented as a needed" with no further view of a Physician's Order 2013, revealed "d/c opin 0.5 mg. bid PRN due to R dated January 2013, revealed yed a Conazepam 0.5 mg. on at 8:00 a.m., and the | F 5 | 14 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolet:

Event ID:7UKE11

Facility ID: YN9009

If continuation sheet Page 15 of 16

PRINTED: 01/23/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SU COMPLE | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|------------------------|-------------------------------|--|
| | | 445024 | B. WING | | 01/09/2013 | | |
| | ROVIDER OR SUPPLIER ALTHCARE, JOHNSO | N CITY | 320 | EY ADDRESS, CITY, STAYE, ZIP CODE 08 BRISTOL HWY DHNSON CITY, TN 37601 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | NTEMENT UP DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDEN'T FYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (XS) COMPLETION DATE | |
| F 514 | included on the Ph the MARs in Nover January 2013. Interview with the : Coordinator on Jar confirmed the resid Orders and MARs | age 15 systolan's Recap Orders and mber and December 2012 and 300 Hall Resident Care huary 10, 2013, at 10:10 a.m., dent's Physician's Recap for November and December 2013 were incorrect | F 514 | | | | |
| FORM CMS | 2567(02-99) Previous Versio | ans Obsolete Event ID: 7UKE | 11 Fa | celly ID: TN9002 If | continuation she | et Page 16 of 16 | |